South Dakota Board of Nursing
Unlicensed Assistive Personnel
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 Fax: (605) 362-2768

UMA Waiver Application

ALL applicants must complete the 4 hour lab/clinical portion of the Medication Aide Training Program and pass the SDBON exam.

RNs and LPNs with active licenses can practice under their nursing license and do not need to be listed on the UMA registry.

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. **Fax this completed application to the address listed above or email to Ashley.Kroger@state.sd.us. *Allow up to 5-7 business days* for the SDBON to process your application. Upon approval the BON will email the approved proctor the access information to allow you to take the SDBON online exam.**

Please Print

Name: First_____ Middle_____ Last _____

Other names previously used:_____

Mailing Address:_____ City_____ State_____ Zip_____
Street/PO Box

Telephone: Home: (___) _____ Cell: (___) _____ Other: (___) _____

Email: _____ **Date of Birth**:_____

Social Security #: _____ **Gender**: ❑Male ❑Female

Ethnicity: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

1. Submit with this application:

☐ Copy of student's school transcript, grade report, or other school documentation verifying successful completion of a Pharmacology course and/or a Fundamentals in Nursing Course that includes theory, lab, and clinical in the area of medication administration.

OR

☐ Provide RN/LPN license number and state/jurisdiction of that license (RNs and LPNs with **active** licenses practice under their nursing license and do not need to be listed on the UMA registry).

Number: _____ State: _____ Expiration Date: _____

(**Note:** South Dakota Board of Nursing will verify the licensure status of the nurse; if a nurse has had any disciplinary action, BON staff will review and determine whether or not the individual may be placed on the South Dakota Medication Aide Registry.)

2. RN Attestation.

I, _____, RN verify that I completed 4-hours medication administration clinical/lab training with the individual identified on this application, that the applicant is capable of performing all the skills listed on the SD Board of Nursing's approved Skills Competency Checklist safely and competently, and that the applicant is eligible to take the medication aide exam.

RN Signature: _____ **RN License #:** _____ **Date:** _____

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3. SD Board of Nursing Approved Test Proctor Information.

Name of SDBON Approved Proctor:	Proctor's Phone:	Proctor's Email Address:

4. Do you currently owe child support arrearages in the sum of $1,000 or more? ❒YES ❒NO
If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

5. Affidavit
I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Medication Aide Applicant Signature **Date**

This section to be completed by the South Dakota Board of Nursing

Date Application Received:	Date Application Denied:
Date Approved:	Reason for Denial:
Board Representative:	Date Notice Sent to Student and / or Nursing Facility:

Updated: 07/2017